REQUEST FOR SPECIAL FORMULA
Massachusetts WIC Program

Participant's Name: _____ **Date of Birth:** _____

HEALTH CARE PROVIDER: PLEASE COMPLETE THIS SECTION

The Massachusetts WIC Program endorses breastfeeding as the optimal way to feed most infants. If infants do receive formula, we support the American Academy of Pediatrics recommendation that all formula fed infants receive iron-fortified formula for the first year. **In accordance with this recommendation, the Massachusetts WIC Program's standard contract formulas are Enfamil with Iron and Prosobee.**

- All other non-metabolic formulas (i.e., Similac, Isomil) will be available in powder only. Infants will be reintroduced to Enfamil with Iron or Prosobee in 1 - 2 months or at 6 months of age, whichever comes first.
- WIC does not provide whole cow's milk for infants.
- Low-iron formula is only available with documentation of chronic hemolytic anemia, hereditary sperocytosis thalassemia, chronic aplastic anemia, sickle cell anemia, hemochromatosis, hemosiderosis and neonatal iron storage disease.

The request for a special formula is subject to WIC approval prior to issuance. A WIC Nutritionist will complete a thorough dietary assessment to verify the need for the requested formula. Significant findings will be communicated to you with the participant's permission. **It is WIC's policy to re-evaluate the participant's continued need for the formula on a periodic basis.**

Has Enfamil with Iron and/or Prosobee been tried? ___ Yes ___ No

Medical Diagnosis/Reason for Request: _____

_____

Recommended Formula:_____ Duration: _____ months

Feeding Instructions: _____

Comments: _____

Physician's or Nurse Practitioner's signature: _____ Date: _____

WIC Use Only:

Date received _____ ID _____ Site _____

Food Package _____ Category P B N I F C Next appointment _____

Comments _____

Nutritionist's signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO WIC

I _____authorize _____
(Print Name) (Doctor, Nurse, Healthcare Provider, Hospital)

to release the following information about me or my child (indicate by checking the following boxes which information about you or your child you want to share with WIC):

Medical diagnosis

Recommended formula and feeding instructions

Other health information as needed

to the Massachusetts WIC Program and the _____local WIC Program located at (specify address):

_____

_____

_____

_____

for the purpose of assessing the need for special formula.

I understand that I do not have to give authorization to my healthcare provider to share health information about me and/or my child with WIC but I want to.

I understand that I can change my mind and cancel this authorization at any time. To do this, I need to write a letter to my healthcare provider and send it or bring it the place where I am now giving this authorization. Once the information has already been given out by my healthcare provider, I understand that it is too late for me cancel the authorization.

Authorized Signature: _____

Relationship to Participant: _____

Date: ____/_____/_____

This authorization is valid for 12 months after the above date.
WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law. WIC is an equal opportunity provider.